

INSTRUCTIONS FOR COMPLETION OF THE AIDS MEDI-CAL WAIVER PROGRAM MEDI-CAL PROVIDER APPLICATION

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) and a Medi-Cal Provider Agreement (DHS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

Enrollment action requested (check all that apply). Enter the date you are completing the application.

“New provider”—the applicant is not currently enrolled in the Medi-Cal program and would like to have a Medi-Cal provider number issued.

For any of the following actions, include current Medi-Cal number:

“Change of business address”—the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

“Additional business address”—the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

“Change of ownership”—there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

“Sale of assets (50 percent or more)” —fifty (50) percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

“New Taxpayer ID number”—a new Taxpayer Identification Number (TIN) is issued by the IRS.

“Cumulative change of 50 percent or more in ownership or control”—there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

“Add rendering provider”—add a rendering provider to a provider group applicant or an existing provider group. If this is a request to be added as a rendering provider to a provider group applicant, enter the provider group name. If this is a request to be added as a rendering provider to an existing provider group, enter that provider group provider number.

“Continued enrollment”—the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current Medi-Cal provider number(s).

Check the box labeled “I intend to use my current...” if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51(b).

“Type of entity”—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. “Legal name”—the name listed with the Internal Revenue Service (IRS).
2. “Business name”—the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application.
3. “Business telephone number”—the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. “Business address”—the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable. Check box a. if this address is a licensed hospital/health facility. Check box b. if all services are provided at this address. Check box c. if you are requesting an exception pursuant to Welfare and Institutions (W&I) Code, Section 14043.15(b)(2). Attach a list of qualifying addresses.

5. "Pay-to address"—the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
 6. "Mailing address"—the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
 - 7.–9. These questions are not applicable to the AIDS Medi-Cal Waiver Program.
 10. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
 - 11.–18. These questions are not applicable to the AIDS Medi-Cal Waiver Program.
 19. "Printed name of provider"—print the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to the California Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
 20. Check (✓) the gender of the individual named in number 19.
 21. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 19. Attach a legible copy to the application.
 22. Enter the date of birth of the individual named in number 19.
 23. Enter the social security number of the individual named in number 19. Provision of the social security number is optional (see Privacy Statement on page 4).
 24. An original signature of the individual named in number 19 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.
 25. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.
- ✓ Remember to attach a legible copy of the following, if applicable:
- ☐ Driver's license or state-issued identification card
 - ☐ TIN verification
 - ☒ ~~CLIA Certificate~~
 - ☒ ~~License, certification, or other approval~~
 - ☐ Fictitious Business Name Statement/Permit
 - ☒ ~~State Laboratory License/Registration~~
 - ☐ Signed Medi-Cal Provider Agreement (DHS 6208)
 - ☐ Signed Medi-Cal Disclosure Statement (DHS 6207)



AIDS MEDI-CAL WAIVER PROGRAM MEDI-CAL PROVIDER APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: California Department of Health Services
Office of AIDS
Community-Based Care Section
MS 7700
P.O. Box 997426
Sacramento, CA 95899-7426
(916) 449-5900

FOR STATE USE ONLY

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply)

☐ New provider

Date

For any of the following actions, include current Medi-Cal number: _____

☐ Change of business address

☐ Additional business address

☐ Change of ownership

☐ Sale of assets (50 percent or more)

☐ New Taxpayer ID number

☐ Cumulative change of 50 percent or more in ownership or control

☐ Add rendering provider to:

☐ Provider group applicant—group name: AIDS Medi-Cal Waiver
Program (Home and Community-Based Waiver)

☐ Existing provider group—specify group provider number(s): _____

☐ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)

☐ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51(b).

Type of entity (check one)

☐ Sole proprietor

☐ Partnership

☐ Government

☐ Corporation:

☐ Limited liability company:

☐ Nonprofit

Corporate number: _____

Corporate number: _____

Type of nonprofit: _____

State incorporated: _____

State incorporated: _____

☐ Other: _____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different 3. Business telephone number ()

Is this a fictitious business name?

☐ Yes ☐ No

If yes, list the Fictitious Business Name Statement/Permit number Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street) City County State Nine-digit ZIP code

a. ☐ This address is a licensed hospital/health facility

b. ☐ All services are provided at this location.

c. ☐ I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all qualifying addresses.

5. Pay-to address (number, street, P.O. Box number) City State Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number) City State Nine-digit ZIP code

7. License number (attach legible copy) License effective date License expiration date 8. Provider type 9. Medicare billing number
NOT APPLICABLE NOT APPLICABLE NOT APPLICABLE AIDS Medi-Cal Waiver Program NOT APPLICABLE

10. Taxpayer Identification Number (TIN) issued by the IRS (attach a legible copy of the IRS form) 11. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 4.)
NOT APPLICABLE

12. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy) 13. State Laboratory License/Registration number (attach a legible copy) 14. Driver's license or state-issued identification number and state of issuance (attach a legible copy)
NOT APPLICABLE NOT APPLICABLE NOT APPLICABLE

15. Date of birth 16. Gender 17. Any local business license numbers, permits (attach a legible copy(ies)) If N/A, provide explanation. 18. Seller's Permit number (attach a legible copy)
NOT APPLICABLE ☐ Male ☐ Female NOT APPLICABLE NOT APPLICABLE

Information About Individual Signing This Application

19. Printed name of provider (last) (first) (middle)			20. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
21. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	22. Date of birth	23. Social security number (Optional—see Privacy Statement below.) _ _ _ _ _ - _ _ _ _ _ - _ _ _ _ _	
24. I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.			
Signature of provider		Title	
Executed at: _____, _____ on _____ (City) (State) (Date)			

25. Notary Public—Please see instructions under number 25 for who must notarize.